EYE CARE
GROUP CLAIM FORM

Group Claim Office / P.O. Box 82520, Lincoln, NE 68501
Toll Free No.: 800-255-4931 / www.ameritasgroup.com

AMERITAS LIFE INSURANCE CORP.
AN AMERITAS ACACIA COMPANY

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME *(Last, First, Middle)*	2. PATIENT'S BIRTHDATE	3. PATIENT'S SEX ❑ M ❑ F	4. RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other

5. INSURED'S NAME *(Last, First, Middle)*	6. INSURED'S SOCIAL SECURITY NO.	7. INSURED'S BIRTHDATE

8. INSURED'S STREET ADDRESS	9. NAME OF EMPLOYER / GROUP NUMBER

10. CITY, STATE, ZIP CODE

11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? ❑ **Yes** ❑ **No** **If YES, please complete boxes 12 through 16.**	12. NAME AND ADDRESS OF OTHER CARRIER

13. INSURED'S NAME	14. RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other	15. INSURED'S BIRTHDATE	16. INSURED'S SSN / GROUP NUMBER

17. THIS SECTION MUST BE COMPLETED WITH *EACH* CLAIM SUBMISSION *ONLY* IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? ❑ Yes ❑ No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AMERITAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE OF INSURED _____ DATE _____

I HEREBY AUTHORIZE **PAYMENT** FOR ANY BENEFITS TO THE BELOW NAMED DOCTOR/DISPENSER.

SIGNATURE OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME *(Last, First, Middle)*	2. TITLE ❑ D.O. ❑ M.D. ❑ O.D.

3. DOCTOR'S STREET ADDRESS	4. CITY, STATE, ZIP CODE

5. PHONE	6. WERE EYEGLASSES PRESCRIBED? ❑ YES ❑ NO WERE CONTACTS PRESCRIBED? ❑ YES ❑ NO	7. HAS CATARACT SURGERY BEEN PERFORMED? ❑ YES ❑ NO	**8. EXAMINATION DATE** PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)

9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER.	10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.
Doctor's Tax I.D. # _____	DOCTOR'S SIGNATURE _____ DATE _____

11. DIAGNOSIS OR NATURE OF OFFICE VISIT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL					MFG.			ZYL ☐	METAL ☐	RIMLESS ☐	COMBO ☐	
LENSES	# OF LENSES ☐	GLASS ☐	PLASTIC ☐		SV ☐	BIF ☐	TRI ☐	PAL ☐	SAFETY ☐	OTHER			
LENS OPTIONS	OS ☐	TINT ☐	GRAD ☐	DBL GRAD ☐	COAT ☐	UV400 ☐	FACET ☐	PHOTO CHROMIC ☐	OTHER				
CONTACT LENSES	# OF LENSES	HCL ☐	SCL ☐	HGP ☐	DISPOS-ABLE ☐	SPH ☐	BIF ☐	TORIC ☐	EW ☐	TINT ☐	NUMBER REPLACED	OTHER	

DATE ORDERED	DATE DISPENSED	OTHER SERVICES

DISPENSING OFFICE _____ PHONE _____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.

DISPENSER'S SIGNATURE _____ DATE _____

12.	AMOUNT
EXAMINATION CHARGE	
FRAME CHARGE	
LENS CHARGE	
OPTIONS CHARGE	
CONTACT CHARGE	
OTHER SERVICES	
SUBTOTAL	
SALES TAX (If Applicable)	
TOTAL CHARGES	$0.00
AMOUNT PAID BY PATIENT	

Instructions

A. Please print or type the insured portion of this form, in full, to assure prompt reimbursement. The insured should sign and date this form when work is completed.

B. If two different providers are involved in providing the examination and the frame, lenses or contact lenses, then each provider should complete the appropriate section of the form.

C. After the form has been fully completed it should be mailed to the address shown on front of form.

ABBREVIATIONS

FRAME

MFG .....manufacturer
ZYL.....plastic
COMBO .....combination (Zyl/Metal)

LENSES

SV.....single vision
BIF .....bifocal
TRI.....trifocal
PAL.....progressive add lenses

LENS OPTIONS

OS.....oversize
GRAD.....gradient

CONTACT LENSES

HCL.....hard contact lenses
SCL .....soft contact lenses
HGP .....hard gas permeable
SPH .....spherical
BIF .....bifocal